

Exhibit 11



Universal Health Group

Internal Medicine • Chiropractic • Physical Therapy
Massage Therapy • Pain Management

Patient Name: Redacted
Date of Eval: 12/23/08

Current Symptoms:

Patient is a 55 year-old white female who presents to the office today for an initial evaluation of injuries sustained in a motor vehicle accident on 11/27/08. Patient states she was the driver of her vehicle when she was in the left turn lane, and was rear ended by a tow truck. Patient states that she followed up with her physician, who did x-rays of her cervical, thoracic and lumbar spine, which were negative. Patient states that since the time of the accident, has had continuous pain and stiffness in her cervical, dorsal and lumbar spine, with radiation down her left arm and left leg. Patient also complains of intermittent headaches.

Past Medical/Surgical History:

Denies medical history. Surgical history: Cholecystectomy. Hiatal hernia repair. Right knee arthroscopy for torn meniscus. C-section.

Family and Social History:

Denies tobacco, alcohol or illicit drug use. Is married with four children. Mother is alive with Alzheimer's. Father is alive and healthy.

Employment History:

Working for Detroit Media Relations, delivering newspapers. Is still working at this time.

Medications:

Denies.

Allergies:

Penicillin and sulfa.

ORIGINAL

RE: Redacted

12/23/08

Page 2

Review of Systems:

All systems reviewed and are negative.

Physical Exam:

Patient is in no acute distress. Vital signs are stable. BP 122/82, P 80, R 16. Patient is alert and oriented x 3. HEENT: Normocephalic atraumatic. PERRLA. EOMI. Throat: Clear. Heart: RRR, without murmur. Lungs: Clear to auscultation. Abdomen: Soft and nontender. Extremities: Full ROM without edema. No joint tenderness. Musculoskeletal: Tenderness to palpation over the paravertebral muscles in the cervical, thoracic and lumbar spine bilaterally with muscle spasms and decreased ROM. Neuro: Cranial nerves II-XII grossly intact. Strength 5/5. DTR's are 2+ equal bilaterally. No sensory or motor loss. No focal neuro deficits.

Impressions:

1. Cervical, thoracic and lumbar sprain.
2. Cervical and lumbar radiculopathy.
3. Cephalgia.
4. Muscle spasms.

Treatment Plan:

1. Patient is to continue with chiropractic treatment and therapy.
2. Patient is to continue with her home exercise program as reviewed with patient.
3. Patient given prescription for Flexeril 10 mg ½ tablet qhs prn #30. Patient told to take Tylenol Extra Strength 1 or 2 tablets q6h during the daytime as needed.
4. Patient is to return to the Westland office in one month for reevaluation. Discuss possible future diagnostic studies as far as MRIs and treatment options.

Sincerely,



Loren Chudler, DO
LC/jc

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM
PO BOX 2361
BLOOMINGTON IL 61702

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) OTHER <input checked="" type="checkbox"/> (ID)				1a. INSURED'S I.D. NUMBER (For Program in Item 1) 22A915984	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted				3. PATIENT'S BIRTH DATE Redacted SEX <input type="checkbox"/> F <input checked="" type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted				5. INSURED'S DATE OF BIRTH Redacted SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. EMPLOYER'S NAME OR SCHOOL NAME STATE FARM	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>				9. INSURANCE PLAN NAME OR PROGRAM NAME BLUE CROSS BLUE SHIELD	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED <u>SIGNATURE ON FILE</u> DATE <u>01 21 09</u>				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED <u>SIGNATURE ON FILE</u>	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 01 21 09		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 17a. 1164477816 17b. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE LOREN CHUDLER DO		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. RESERVED FOR LOCAL USE	
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO CHARGES 0 00		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 839 06 2. 839 21 3. 839 20 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 12 23 08 12 23 08		B. PLACE OF SERVICE 11 C. EMG 99205		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER 1	
E. DIAGNOSIS POINTER 1		F. \$ CHARGES 250 00		G. DAYS OR UNITS 1	
H. EPST Family Plan NPI		I. ID DUAL 1164477816		J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX I.D. NUMBER 205918486 SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 0001C000640		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$ 250 00		29. AMOUNT PAID \$ 37 00		30. BALANCE DUE \$ 213 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) LOREN CHUDLER DO SIGNED <u>01 21 09</u> DATE		32. SERVICE FACILITY LOCATION INFORMATION UNIVERSAL HEALTH GROUP 5761 W MAPLE RD WEST BLOOMFIELD MI 48322		33. BILLING PROVIDER INFO & PH # (248) 9322607 UNIVERSAL HEALTH GROUP 5761 WEST MAPLE ROAD WEST BLOOM MI 48322 1518027606	

790-0123 (08-05) (OCR) (PT)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101-41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. **DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS**



Universal Health Group

Internal Medicine • Chiropractic • Physical Therapy
Massage Therapy • Pain Management

Patient Name:

Redacted

Date of Eval:

07/14/2009

ORIGINAL

B002-228

Current Symptoms:

Patient is a 68 year old black female who presents to the office today for an initial evaluation of injuries sustained in a motor vehicle accident on 06/15/2009. Patient was in the back seat of a vehicle, when going through an intersection was hit by another car on the passenger side going at a high rate of speed. Patient states she was wearing her seatbelt. Patient did not follow up in the emergency department; however, went to her family physician the next day. Patient states she is complaining of right sided chest pain, left shoulder pain, and pain in her cervical, dorsal and lumbar spine. Patient states her family physician did do x-rays of her ribs which was negative study. Patient states she is also having left knee pain. Patient also complains of occasional right eye pain. Patient also complains of posterior headaches.

Past Medical History/Surgical History:

Past medical history is hypertension, chronic renal failure, corneal transplant right eye. Past surgical history is left shoulder torn rotator cuff 1995, AV shunt in the left arm and on dialysis since 2006.

Family and Social History:

Denies tobacco, alcohol or illicit drug usage. Patient is divorced with three children. Mother died of sickle cell. Father died of pneumonia.

Employment:

Patient is a retired.

Medications:

Hydralazine, Cartia, vitamin D, Minoxidil, Furosemide, Metoprolol, Rantidine, Cozaar, Warfarin, Clonidine, Sensipar, Zocor, OsCal.

Allergies:

No known drug allergies.

Redacted

07/14/2009

Page 2

Review of Systems:

All other systems are reviewed and are negative.

Physical Exam:

Patient is in no acute distress. Alert and oriented x 3. HEENT: normocephalic atraumatic. PERRLA. EOMI. Throat: clear. Heart: RRR. Lungs: clear to auscultation. Tenderness to palpation over the right anterior chest wall, no crepitus noted. Abdomen: soft and nontender. Extremities: tenderness to palpation over the left anterior shoulder with decreased ROM secondary to pain and anterior left knee. No edema noted, full ROM. No other joint abnormalities. Musculoskeletal: tenderness to palpation over the paravertebral muscles in the cervical, dorsal, and lumbar spine bilaterally with decreased ROM and muscle spasms. Neurologic: cranial nerves II-XII grossly intact. Strength is 5/5. DTR's are 2+ equal bilaterally. No sensory or motor loss. No focal neuro deficits.

Impressions:

1. Cervical, dorsal and lumbar sprain.
2. Right sided chest contusion.
3. Left shoulder sprain.
4. Left knee contusion.
5. Cephalgia.

Treatment Plan:

1. Patient is to continue with chiropractic treatment and begin home exercise program as reviewed with patient.
2. Patient to get an x-ray of left shoulder and left knee.
3. Patient is given prescription for Darvocet N 100, 1 qd prn pain #30.
4. Discussed future possible diagnostic studies with patient including MRI studies and if no improvement over the next two to three months.
5. Patient is to return to the Southfield office in 30 days for reevaluation.

Sincerely,



Loren Chudler, DO
LC/ts

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM
PO BOX 2361
BLOOMINGTON IL 61702

<input type="checkbox"/> PICA						1a. INSURED'S I.D. NUMBER 22B002228					
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted						3. PATIENT'S BIRTH DATE Redacted					
6. INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>					
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH Redacted					
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. EMPLOYER'S NAME OR SCHOOL NAME STATE FARM					
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM					
10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED <u>SIGNATURE ON FILE</u> DATE <u>08 11 09</u>											
14. DATE OF CURRENT: MM DD YY 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE LOREN CHUDLER DO						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES 0.00					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. L847.0 3. L784.0						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
23. PRIOR AUTHORIZATION NUMBER						24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9 CM I. ID. QUAL J. RENDERING PROVIDER ID. #					
1 07 14 09 07 14 09 11 99205 25 1 250.00 1 NPI 1164477816											
2 07 14 09 07 14 09 11 73030 LT 1 55.00 1 NPI 1164477816											
3 07 14 09 07 14 09 11 73562 LT 1 50.00 1 NPI 1164477816											
4											
5											
6											
25. FEDERAL TAX I.D. NUMBER SSN EIN 205918486 <input type="checkbox"/> <input checked="" type="checkbox"/>						26. PATIENT'S ACCOUNT NO. 0002C000892					
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						28. TOTAL CHARGE \$ 355.00					
29. AMOUNT PAID \$ 0.00						30. BALANCE DUE \$ 355.00					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) LOREN CHUDLER DO SIGNED 08 11 09						32. SERVICE FACILITY LOCATION INFORMATION UNIVERSAL HEALTH GROUP 5761 W MAPLE RD WEST BLOOMFIELD MI 48322 2					
33. BILLING PROVIDER INFO & PH # (248) 9322607						UNIVERSAL HEALTH GROUP 5761 WEST MAPLE ROAD WEST BLOOM MI 48322 1518027606					

NUCC Instruction Manual available at: www.nucc.org
Mfd. by Medical Arts Press
Call toll-free: 1-800-328-2179PLEASE PRINT OR TYPE
Printed on Recycled PaperAPPROVED OMB-0938-0999 FORM CMS-1500 (08-05)
#14710 - Medical Arts Press
Use with Envelope #14145 (gummed) or #14148 (self-seal)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured": i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Patient Name: Redacted
Date of Eval: 02/25/2010

Current Symptoms:

Patient is a 75 year old black female who presents to the office today for an initial evaluation of injuries sustained in a motor vehicle accident on 02/05/2010. Patient states she was the driver of her vehicle, when another car hit her on the passenger side while she was pulling out of a parking lot. Patient was wearing her seatbelt. Patient states she followed up at urgent care where she had x-rays which were negative. Patient states, since the time of the accident, has had pain and stiffness in her cervical and lumbar spine, as well as posterior headaches. Patient states she is having difficulty sleeping secondary to the pain and muscle spasms. Pain is worse with bending, twisting and lifting, or bending or movement of her neck. Patient states the pain is an 8 out of 10 sharp pain.

Past Medical History/Surgical History:

Past medical history is hypothyroidism. Past surgical history denied.

Family and Social History:

Denies tobacco, alcohol or illicit drug usage. She is a widow, no children. Mother died of Alzheimer's. Father died of natural causes.

Employment:

Patient is employed as an LPN working at Woodhaven Nursing Home. Unable to work since the accident.

Medications:

Synthroid 0.75 mcg qd.

Allergies:

No known drug allergies.

Redacted

02/25/2010

Page 2

Review of Systems:

All other systems are reviewed and are negative.

Physical Exam:

Patient is in no acute distress. Alert and oriented x 3. Vital signs: P 84, R 18, BP 143/95. HEENT: normocephalic atraumatic. PERRLA. EOML. Throat: clear. Heart: regular RRR. Lungs: clear to auscultation. Abdomen: soft and nontender. Extremities: full ROM without edema, no joint tenderness. Musculoskeletal: tenderness to palpation over the paravertebral muscles in the cervical, dorsal and lumbar spine bilaterally with decreased ROM and muscle spasms. Neurologic: cranial nerves II-XII grossly intact. Strength is 5/5. DTR's are 2+ equal bilaterally. No sensory or motor loss. No focal neuro deficits.

Impressions:

5. Cervical, dorsal and lumbar sprain.
6. Cephalgia.
7. Muscle spasms.

Treatment Plan:

7. Patient is to continue with chiropractic treatment and home exercise program
8. Discussed with patient at length future possible diagnostic studies including MRI studies if no improvement.
9. Patient given prescription for Zanaflex 4 mg 1 qhs prn muscle spasms #30.
10. Patient is to return to the Westland office in one month for reevaluation.

Sincerely,

Loren Chudler, DO
LC/ts

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
FAX 888-845-8680 SEPERATELY
PO BOX 2361
BLOOMINGTON IL 61702

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		TRICARE CHAMPUS (Sponsor's SSN)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK LUNG (SSN)		OTHER (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) U8R5416															
Redacted												8. Redacted		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		Redacted													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER															
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous)		a. INS. Redacted		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F													
b. OTHER INSURED'S DATE OF BIRTH MM DD YY												b. AUTO ACCIDENT?		b. EMPLOYER'S NAME OR SCHOOL NAME															
c. EMPLOYER'S NAME OR SCHOOL NAME												c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM INSURANCE															
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 a-d.													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																	
SIGNED SIGNATURE ON FILE DATE 03 03 10												SIGNED SIGNATURE ON FILE																	
14. DATE OF CURRENT: 02 03 10												15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		FROM MM DD YY TO MM DD YY													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE LOREN CHUDLER DO												17a. NPI 1164477816		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		FROM MM DD YY TO MM DD YY													
19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? \$ CHARGES		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 0 00															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate items 1,2,3 or 4 to item 24e by line)												22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.															
1. 847 0												23. PRIOR AUTHORIZATION NUMBER																	
2. 728 85																													
24. A. DATE(S) OF SERVICE												B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OF UNITS		H. PREVIOUS PAYMENT		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1 02 25 10 02 25 10 11												99205		12		295 00 1								1164477816					
2																													
3																													
4																													
5																													
6																													
25. FEDERAL TAX I.D. NUMBER 205918486												SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 0001C005480		27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 295 00		29. AMOUNT PAID \$ 0 00		30. BALANCE DUE \$ 295 00							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) LOREN CHUDLER DO 03 03 10 SIGNED DATE												32. SERVICE FACILITY LOCATION INFORMATION WESTLAND IM 8191 N WAYNE ROAD WESTLAND MI 48185 1518027606		33. BILLING PROVIDER INFO & PH. # UNIVERSAL HEALTH GROUP 5761 W MAPLE RD WEST BLOOM MI 48322 1518027606															

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured": i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn. PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.